TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ORTHOPEDIC ASSOCIATES OF CENTRAL TEXAS

Respondent Name
TRAVIS COUNTY

MFDR Tracking Number
M4-16-2493-01

Carrier's Austin Representative
Box Number 38

MFDR Date Received
APRIL 18, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "York has never gotten back to us with any eob/denial. I have sent the clams twice with proof of timely within all our records and with the signed certified receipt returned to us from the United States Post Office. They have not answered our request nor have they paid us."

Amount in Dispute: $747.45

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the bill recommending payment for the attached MDR. Check will be issued tomorrow for payment."

Response Submitted By: WellComp Managed Care Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 3, 2015	CPT Code 99203 Office Visit	$312.00	$1.31
	CPT Code 73562	$96.09	$3.06
	CPT Code 99080-73 Work Status Report	$15.00	$0.00
September 11, 2015	CPT Code 99214 Office Visit	$309.36	$171.80
	CPT Code 99080-73 Work Status Report	$15.00	$15.00
TOTAL		$747.45	$191.17

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.

Issues

Is the requestor entitled to additional reimbursement?

Findings

The respondent submitted an explanation of benefits that support payment of $240.38 was issued for date of service September 3, 2015 based upon the fee guideline. The division will determine if additional reimbursement is due per the fee guideline for these services.

Regarding September 11, 2015, the requestor wrote "York has never gotten back to us with any eob/denial. I have sent the clams twice with proof of timely within all our records and with the signed certified receipt returned to us from the United States Post Office. They have not answered our request nor have they paid us." The division finds the payment of $240.38 did not include any services rendered on September 11, 2015, and no explanation of benefits for this date were submitted; therefore, this date will be reviewed per division rules and guidelines.

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2016 DWC conversion factor for this service is 56.82.

The Medicare Conversion Factor is 35.8043

Review of Box 32 on the CMS-1500 the services were rendered in zip code 78758, which is located in Austin, Texas; therefore, the Medicare participating amount is based on locality "Austin, Texas".

Using the above formula, the division finds the following:

Code	Medicare Participating Amount	MAR	IC Paid	Due
99203	$108.59	$172.33	$171.02	$1.31
73562	$36.18	$57.42	$54.36	$3.06
99080-73 (X2)	m/a	$15.00 X 2 = $30.00	$15.00	$15.00
99214	$108.26	$171.80	$0.00	$171.80

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $191.17.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $191.17 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	3/2/2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.